05447

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:
County: Worcester
City or town: Bishop
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Bishop
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lowell Baker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie Mae Baker
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Nov 27, 1873

8. AGE:

Years	Months	Days	If less than one day
73	6	13	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farmer

FATHER
12. Name: Samuel Baker
13. Birthplace: Md.

MOTHER
14. Maiden name: Matilda Ennis
15. Birthplace: Md.

16. Informant: Mrs. Lillie M. Baker.
Address: Bishop, Md.

17. Burial (Burial, cremation, or removal—which?) Date thereof: June 12 1947 (month) (day) (year)
Cemetery or crematory: Bishopville Md.
Location: Bishopville, Md.

18. Funeral director: M. Pdsha Watson
Address: Bishopville Md.

19. 6/11 47 (Date rec'd by registrar) Mary Berger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1947, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1947, to June 10 1947
and that I last saw h... alive on June 10th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury... Injured at work?

23. SIGNATURE: G E Jones M. D. or other
Address: Bishopville, Md. Date signed 6-12-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05448

Reg. Dist. No. 351

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill Rural # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill Rural # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3.(a) FULL NAME O. Frank Burke

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Millie T. Burke
6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) March 2 - 1866

8. AGE:

Years	Months	Days	If less than one day
81	3	6	hrs. min.

9. Birthplace Accomac Virginia (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Sal Libester by Westfall
Address Snow Hill, Md Rural # 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10/47 (month) (day) (year)
Cemetery or crematory Whatcoat
Location Snow Hill, Md
18. Funeral director Elias E. Dennis
Address Snow Hill Md
19. 6/10/47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947 at 9:55 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6/1/47 to 6/8/47
and that I last saw h... alive on 6/8/47

Immediate cause of death Arteriosclerotic Hypertension — DURATION
Due to Heart disease — unknown
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Cohen M.D. M. D. or other
Address Snow Hill Date signed 6/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

460

05449

Reg. Diat. No. 351

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Celine Causey

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 10 - 1867

8. AGE: Years 79 Months 7 Days 16 If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester, Md (Town, County, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Josephus Causey
13. Birthplace: Maryland
MOTHER 14. Maiden name: Caroline Simpson
15. Birthplace: Maryland
16. Informant: Mrs. Irene Causey
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 29/47 (month) (day) (year)
Cemetery or crematory: Christ Church
Location: Snow Hill, Md
18. Funeral director: Elay E. Timmons
Address: Snow Hill Md
19. 6/28 1947 (Date rec'd by registrar) L. Gary Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1947 at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 1944, to June 24 1947
and that I last saw her alive on June 23 1947

	DURATION
Immediate cause of death: Cancer & Cachexia	3 wks
Due to: Carcinoma of ascending Colon with Metastasis	3 to 5 yrs
Due to:	
Other conditions: Marked Scoliosis Cardiac insufficiency	Life.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar, M.D. M. D. or other
Address: Snow Hill Date signed: 6-27-47


JUN 30 1947
U.S. PATENT

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1778

05450

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County Worcester
City or town Rural - Newark (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred: Old Purnell Farm
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)
State Md County Worcester
City or town Rural - Newark (If outside city or town limits, write RURAL and give nearest town)
Street No. Old Purnell Farm - 3 miles of Newark (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Orlando Cornish Jr
3.(b) Social Security Number

4. Sex M
5. Color or race C.
6.(a) Single, married, widowed, or divorced S.
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) March 23rd 1941
8. AGE: Years 6 Months 3 Days 0 If less than one day ... hrs. ... min.
9. Birthplace Salisbury Md (Town, county, and state)
10. Usual occupation at home
11. Industry or business
FATHER 12. Name Thomas Orlando Cornish
13. Birthplace Somerset Co Md
MOTHER 14. Maiden name Doris Audrey Polk
15. Birthplace Fruitland Md
16. Informant Thomas Orlando Cornish
Address Salisbury Md RFD #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26 47 (month) (day) (year)
Cemetery or crematory Methodist
Location Fruitland Md
18. Funeral director Clay C. Dennis
Address Snow Hill Md
19. 6/24/ 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 8:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from examined him after death 19..., to ... 19...
and that I last saw h... alive on dead 6/23/ 1947
Immediate cause of death Poison Drank Black Leaf (Nicotine Sulphate)
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Signature Lecky N. E. Antonius Md. Medical Examiner M. D. or other
Address Pocomoke City Md Date signed 6/23/47

5463

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

CERTIFICATE OF DEATH

Reg. Dist. No. ....

MV

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Non Resident

Hospital, Institution, or street address where death occurred:
State Highway

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Accomac

City or town: Belle Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: Deborah Lynn Dulany

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife ✓

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): July 7, 1944

8. AGE: Years: 2 | Months: 11 | Days: 6 | If less than one day: ... hrs. ... min.

9. Birthplace: Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: None ✓

11. Industry or business

FATHER
12. Name: David L. Dulany
13. Birthplace: Norfolk, Va.

MOTHER
14. Maiden name: Betty Marie Taylor
15. Birthplace: Salisbury, Md.

16. Informant: David L. Dulany
Address: Belle Haven, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/10/47 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: The Hills & Johnson Co.

Address: Salisbury, Md.

19. Oct 13 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1947, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Broken neck	Instant
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of June 8 '47
Where did injury occur? Pocomoke City (City or town) Worcester (County) Md. (State)
Injured at home, farm, industry, public place (where?) Highway # 13
Means of injury Struck by car Injured at work? No

23. SIGNATURE: John L. Riley Dep. Med. Examiner
M. D. or other
Address: Snow Hill Md. Date signed 6/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940a

05451

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nathan Conway Hall.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Kate Hall. 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Feb 2 1863

8. AGE: Years 83 | Months 7 | Days 27 | If loee than one day ... hrs. ... min.

9. Birthplace Berlin Md
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or buelnoss

FATHER 12. Name Elisha Hall
13. Birthplaco Md

MOTHER 14. Maiden name Sarah Stuart
15. Birthplace Md

16. Informant Mrs. Howard Hall
Address Berlin Md

17. (Burial, cremation, or removal. Which?) B— Dato thereof 6/23/47 (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin Md

18. Funeral director Burna A. Burbage
Address Berlin Md

19. 6-29- 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 June 1947, at 10 10 P.M.

21. I CERTIFY that death occurred on the dato above etated; that I attended deceased from 21 June 1947, to 21 Jun 1947 and thal I last saw h ... alive on ... 19...

Immediate cause of death	DURATION
Acute Coronary Thrombosis	5 min.
Due to Coronary sclerosis	
Duo to Atherosclerosis Generalizata	
Dthor conditione	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was duo to external causes, fill in the following:
Accident, euicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ...
Meane of injury ... Injured at work?

23. SIGNATURE Herman A. Rabbitt M.D. M. D. or other
Address 5 Bay St. Berlin Md Dato signed 24 June 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

87c

05452

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH

County: Worcester Co

City or town: Ocean City Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Second 1st St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME Blanche Tenney

3.(b) Social Security Number 214-24-4347

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	D K

6.(b) Name of husband or wife: D K

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): D K 1897

8. AGE: Years: 50 | Months: D K | Days: D K | If less than one day: ..... hrs. ..... min.

9. Birthplace: D K (Town, county, and state)

10. Usual occupation: Cook + Housework

11. Industry or business: at Private Homes.

FATHER

12. Name: D K

13. Birthplace: D K

MOTHER

14. Maiden name: D K

15. Birthplace: D K

16. Informant: Loanta Carter

Address: Ocean City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28-47 (month) (day) (year)

Cemetery or crematory: [illegible]

Location: [illegible] Norfolk Va

18. Funeral director: James F Stewart

Address: Baltimore Md

19. 6-27 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1947, at 2.30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22nd 1947 to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Probably Angina Pectoris — DURATION

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: M. Eastman Md Exam M. D. or other

Address: Ocean City Md Date signed 6/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

166

05456

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Worcester

City or town: Rural - Snow Hill Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Same Months

Hospital, Institution, or street address where death occurred: Farmers Tenant House Ralph Shockley Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill Rural #3 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Cassie Virgie Ross Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C.	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15th 1931

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
16	1	13		

9. Birthplace: Worcester (Town, county, and state)

10. Usual occupation: Field work

11. Industry or business:

FATHER 12. Name: Irvin Johnson

13. Birthplace: Greensboro N.C.

MOTHER 14. Maiden name: Beulah Ross

15. Birthplace: Pocomoke

16. Informant: Beulah Ross

Address: Snow Hill Md RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2/47 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: near Pittsville Md

18. Funeral director: Elay E. Timmons

Address: Snow Hill Md.

19. 7/1 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28th 1947, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26th 1947, to June 28th 1947

and that I last saw h alive on May 13th 1931

Immediate cause of death	DURATION
Hemorrhage	
Due to Laceration of Brain	
Due to Bullet wound	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide (Homicide) Date of 6/28/47

Where did injury occur? near Snow Hill (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot by a rifle ball Injured at work? Presumably Not

23. SIGNATURE: N. E. Antonine M.D. M. D. or other

Address: Ocean City Md Date signed 6/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

05453 335

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
County Worcester
City or town Newark (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: R.D.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED (For newborn infants give residence of mother)
State Md County ~~Worcester~~ Wicomico Co
City or town ~~Newark~~ Powellville (If outside city or town limits, write RURAL and give nearest town)
Street No. ~~R.D.~~ in Village (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Catherine Millie Kelley
3. (b) Social Security Number

4. Sex female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife John W. Kelley
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) Oct 8 - 1860
8. AGE: Years 86 Months 7 Days 28 If less than one day ... hrs. ... min.
9. Birthplace Whaleyville Md (Town, county, and state)
10. Usual occupation House wife
11. Industry or business at Home
FATHER 12. Name Henry Lewis
13. Birthplace Whaleyville Md
MOTHER 14. Maiden name Nancy
15. Birthplace Whaleyville Md
16. Informant Mr. Maude Bradford
Address R.D. Newark Md
17. B (Burial, cremation, or removal. Which?) Date thereof June 8-47 (month) (day) (year)
Cemetery or crematory St. Johns Cem.
Location Powellville Md
18. Funeral director Holloway & Walter K. Holloway
Address Salisbury Maryland
19. 6-7-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 7:30 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 May 1947, to 6 Jun 1947
and that I last saw her alive on 6 Jun 1947

	DURATION
Immediate cause of death Chronic degenerative myocarditis	5 yrs
Due to Senility	
Due to	
Other conditions Abdominal Hernia - 0 patient unoperated (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. Hallahan M.D. M. D. or other
Address Berlin, Md Date signed 6 Jun 47

VS A15 9-45-15M

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

05454

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Ida V Outten

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Leonard Outten
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): January 7-1861

8. AGE: Years	Months	Days	If less than one day
86	4	29	...hrs. ...min.

9. Birthplace: Pocomoke, Worcester Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Luther Ward
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lizzie Mason
15. Birthplace: Maryland

16. Informant: Harry D. Outten
Address: Pocomoke Md.

17. Burial — Date thereof: June 8-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Goodwill Cemetery
Location: Rural Pocomoke Md.
18. Funeral director: Henry H Watson
Address: Pocomoke Md.

19. June 9 1947 — Anne E. White, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1947 at 12:05 P.M.

21. I HEREBY CERTIFY that death occurred on the date above stated; that I attended deceased from May 22nd 1947 to June 3rd 1947 and that I last saw her alive on June 3rd 1947

Immediate cause of death	DURATION
Due to: Arterio Sclerosis	
Due to:	
Other conditions: Paralysis of [illegible] [illegible]	Since April 47
Diarrhea	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: N. E. Fontano M.D. (M. D. or other)
Address: Pocomoke City Md. Date signed: 6/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

05455

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Jane W. Payne

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Silas R Payne
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 19. 1854
8. AGE: Years: 92 Months: 9 Days: 11 If less than one day: ... hrs. ... min.
9. Birthplace: Pocomoke Worcester, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —
12. FATHER — Name: George W. Hancock
13. FATHER — Birthplace: Md.
14. MOTHER — Maiden name: Anne E. Bonsille
15. MOTHER — Birthplace: Md.
16. Informant: Mrs. Lucille Stevenson
Address: Pocomoke City, Md.
17. Burial (Burial, cremation, or removal: Which?) Date thereof July 3 1947 (month) (day), (year)
Cemetery or crematory: Pusey Jerdan Cemetary
Location: Pocomoke City, Md.
18. Funeral director: Henry L. Dalton
Address: Pocomoke City Md.
19. July 1, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1947 at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to June 30 1947 and that I last saw her alive on June 29 1947

	DURATION
Immediate cause of death: Uremia	6 days
Due to: Nephritis, Chronic	unknown
Due to: Arteriosclerosis	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Paul Cohen M.D. M. D. or other
Address: Snow Hill Date signed 7/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

CERTIFICATE OF DEATH

05457

Reg. Dist. No. 357

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

WITHIN CORPORATE LIMITS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Wilson Ruggles Van Order

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edith Van Order
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): April 14 1879

8. AGE:

Years	Months	Days	If less than one day
68	2	2	hrs. min.

9. Birthplace: Bath New York (Town, county, and state)
10. Usual occupation: U.S. Census Absent
11. Industry or business: Snow Hill Md
12. FATHER — Name: Nezakiah Van Order
13. Birthplace: New York
14. MOTHER — Maiden name: Sarah Foster
15. Birthplace: New York
16. Informant: Mrs Edith Van Order
Address: Snow Hill Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19/47 (month) (day) (year)
Cemetery or crematory: Grace
Location: Lyndenburg N.Y.
18. Funeral director: LeRoy O. Dennis
Address: Snow Hill, Md
19. June 16 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1947, at 12:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —
and that I last saw h — alive on — 19 —

Immediate cause of death	DURATION
Myocardial degeneration of heart	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other
Address: Snow Hill Md Date signed 6/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

CERTIFICATE OF DEATH

05458

Reg. Dist. No. 357

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Virginia L. Vincent

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
8.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Clarence L. Vincent
6.(c) If alive, give age: ....years
7. Birth date of deceased (mo., day, yr.): Dec. 5 - 1864

8. AGE: Years: 83 Months: 4 Days: 14 If less than one day: ....hrs. ....min.

9. Birthplace: Berlin Worcester Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Samuel Payne
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sara Burbage
15. Birthplace: Maryland

16. Informant: Dr. John T. Riley
Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 22/47 (month) (day) (year)
Cemetery or crematory: Presbyterian
Location: Snow Hill, Md
18. Funeral director: Elias C. Timmons
Address: Snow Hill Md

19. 6/21 1947 (Date rec'd by registrar) L. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1947, at 6.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947, to June 19 1947, and that I last saw her alive on June 19 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 hour
Due to: arterio-sclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul Chen M. D.
M. D. or other
Address: Snow Hill Date signed: 6/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05459

Reg. Dist. No. 354

1. PLACE OF DEATH:

County Worcester

City or town Stockton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Melbourne, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Wise Ward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) December 11, 1872

8. AGE: Years	Months	Days	If less than one day
74	6	1	hrs. min.

9. Birthplace Melbourne, Worcester, Md. (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Noah Ward

13. Birthplace Md

MOTHER 14. Maiden name Charlotte Pilchard

15. Birthplace Md.

16. Informant Mr. Grover Ward

Address New Church, Va Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15, 1947 (month) (day) (year)

Cemetery or crematory Pilchard

Location Pocomoke City, Rural

18. Funeral director Margarette H. Watson

Address Pocomoke City, Md.

19. June 13 1947 (Date rec'd by registrar) Mary M Tuyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to June 12 1947

and that I last saw her alive on June 11 1947

Immediate cause of death	DURATION
Cortens selerotic Hypertension	
heart disease	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Cohen M.D. M. D. or other

Address Snow Hill Date signed 6/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M